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ABSTRACT

This paper presents a parent training program developed as an alternative, non-residential treatment approach for families of delinquent youths. When a child is referred to the clinic for behavior problems such as aggressiveness, disobedience, theft, and truancy, the program includes the parents in the total treatment. The major goal is to teach parents skills that will allow them to modify their children's undesirable behavior and prevent future problems. Group and individual training techniques are used, including parent training and consultation, youth skill training, and school contacts. Evidence collected indicates that the parents' use of the skills they were taught had a significant impact on changing their children's behavior. (PFS)

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A COMPREHENSIVE EARLY INTERVENTION PROGRAM FOR FAMILIES WITH PROBLEM CHILDREN

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SUMMARY

The effectiveness of an early intervention program using principles of the Teaching-Family Model (Phillips, Phillips, Fixsen, and Wolf, 1974) for families with problem behavior children was studied in a military out-patient mental health clinic. School and self-referred military families were randomly assigned to the experimental and control groups. Fourteen families participated in the experimental program which consisted of: (1) a five day parent training workshop followed by four to six individual consultation sessions with one of three program trainers; (2) a youth group program that met once weekly for seven weeks; and (3) school consultation consisting of an initial interview between a program trainer and a youth's teacher, followed by seven weekly telephone contacts. Eleven families in the control group received the predominant treatment method for childhood behavior problems being employed in the clinic -- fifty-minute weekly individual sessions with one of two behaviorally oriented child psychologists whose treatment strategies included assessment of parent-child interactions in playroom activities, instructions to parents in how to listen and express interest to their children, and assistance in designing parent-child behavior contracts.

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Results were obtained for six pre-post treatment measures given to the control and experimental groups. No significant differences were found between the control and experimental group scores on the pre-treatment measures. In post-treatment measurement comparison with the control group, the experimental group showed: (1) more frequent use of positive and negative consequences, rationales, and requests for acknowledgment in parents' written responses to behavior vignettes (Figure 1); (2) more frequent youth compliance in response to parental instructions as observed in structured parent-child interactions (Figure 2); (3) more frequent parental use of contingent praise and reprimands in response to youth compliance and non-compliance, respectively, as observed in structured parent-child interactions (Figure 2); (4) greater parental use of specific behavior descriptions of inappropriate and appropriate behaviors and positive and negative consequences when discussing problem behaviors with their children as observed in structured parent-child interactions (Figure 3); (5) fewer parental reports of youth problem behaviors at home (problem behavior checklist) (Figure 4); and (6) greater youth improvement on classroom problem behaviors as rated by teachers (Figure 5).

Available data collected at five week or five month intervals after treatment indicated that the decrease in parental and teacher reports of youth problem behaviors was maintained for the experimental group.

The authors discuss how the results demonstrated that: (1) the parent-training program produced desired changes in what the parents said

they would do in response to youth behaviors (behavior vignettes); (2) the parents could employ the skills in which they were trained in responding to youth behaviors (parent-child structured interactions); and (3) the youth's behavior improved as indicated by observations of increased compliance by the youths and fewer reports of problem behaviors by teachers and parents.

REFERENCE

Phillips, E. L., Phillips, E. A., Fixsen, D. L., Wolf, M.M. The Teaching-Family Handbook, University of Kansas Printing Services, 1972.

Whitside Presentation

The Whitside Project was initiated at the Fort Riley, Kansas Mental Health Clinic in the fall of 1975. The parent training program was based on principles of the Teaching-Family Model and was developed as an alternative, non-residential treatment approach for families of predelinquent youths. Using group and individual training techniques the Whitside Project provides a comprehensive, early intervention strategy that includes parent training and consultation, youth skill training, and school contacts. The program is designed to include the mother and father, as well as the child referred to the clinic for behavior problems. The children's behavior problems included aggressiveness, disobedience, theft, or truancy. The major goal of the program was to teach parents skills that will allow them to modify their children's undesirable behavior and prevent future problems from occurring.

An evaluation of the project's effectiveness was conducted during the first year. Our major areas of interest were first, the feasibility of training parents using a systematic training package and second, to evaluate the utility of the training package in comparison to the training typically offered at the clinic.

The families of 30 children who were referred by parents, teachers or pediatricians were selected to participate in the study. Each family was selected on the basis of six criteria. First, the families resided

close enough to the clinic to attend the week long workshop and subsequent weekly appointments. Second, the parents gave their informed consent to participate in the research. Third, the target child was between 6 and 13 years. Fourth, the child was reported by parents to be exhibiting aggressive, disobedient, theft or truant behavior. Fifth, the child had not been diagnosed as psychotic, brain-damaged, retarded or seriously physically handicapped. Sixth, any youth having a record of more than one police or court contact was excluded. Families who met these criteria were randomly assigned to the experimental training program or to the control training program so that there were originally 15 families in each group. Due to dropouts, however, the resulting number was 14 families in the experimental training program and 11 in the control training program.

The 11 control families received the predominant treatment method employed in the clinic. The control treatment typically involved meeting with one of two behaviorally-oriented child psychologists weekly for 50 minutes. The control treatment strategies included assessing parent-child interactions in playroom activities, instructing parents in how to listen and express interest to their children, teaching parents to apply contingent praise and tangible rewards to specific behaviors, and assisting parents in designing parent-child behavior contracts.

The experimental training program involved a 5-day parent-training workshop, 10 weekly consultation sessions with parents, a youth training group which met weekly for 8 weeks, and weekly contact with the youth's teachers.

The parent training workshop was adapted from the Teaching-Family Model for group home residential care. The format of the parent-training workshop included: didactic instruction; open discussion; video-tape demonstrations of "right" and "wrong" way parent-youth interactions; and structured role-playing practice of the parent-youth interaction skills. A "Parent Training Manual" also was given to the parents to supplement the workshop presentations.

Following the workshop, the parents were randomly assigned to one of the three trainers for weekly individual consultation sessions. In these meetings the trainer answered questions parents had about implementing skills learned in the workshop, praised every attempt they were making to implement the program, empathized with any problems they were having, and assisted the parents in reassessing youth target behaviors and planning treatment strategies.

The third components, the Youth Skills Training Group met weekly for 8 half-day sessions. Trained staff members met with the youths to teach them skills that were considered most difficult for the parents to teach. A typical Youth-Training Group involved defining, discussion and role-playing selected social skills such as giving compliments, cooperative behavior, accepting criticism and appropriate instruction following. The youths also were observed working as a group on craft projects, playing team sports, and going on outings. These activities provided opportunities for the youths to practice the selected social skills and for the trainer to continue teaching and refining their social skills.

The final component of the treatment program involved school-contacts by the trainer who worked with an individual family. Before or during the parent-training workshop the trainers met with the youths' teachers. The purpose of the meeting was to establish a cooperative relationship and to explain the objectives and procedures of the clinic program to tne teacher. The teacher was asked to describe any of the youth's problem behaviors in the classroom. The school behaviors targeted by the teacher were then dealt with by the parents in the home and by the youth training group leaders.

Our primary questions in the Whitside project were:

First, could we effectively teach the skills to natural parents?

Second, would the parents employ the skills in interactions with their children?

And third, would the parents' use of the skills makes a difference in the childrens' behavior?

In response to the first question -- would the parent-training program be effective in teaching the parents new skills -- we found that the parents did learn many of the behaviors the training program attempted to teach.

SHOW SLIDE FIGURE 1

One of the measures used to answer this question was the administration of several matched sets of vignettes - a paper and pencil instrument - which were presented in counter-balanced order before and after treatment to both the experimental and control group parents. Each vignette

described a scene in which a child might be performing "good" or "bad" behaviors. For example, one vignette read: "Your son's room has been a mess all week. This morning you noticed his bed is neater but the rest of the room is still a mess." The parents' task was to give written responses to each scene describing how they would deal with the youth's behavior if the youth were their own child. Trained raters scored the parents' responses by counting the number of trained behaviors included at least once in the parents' response: (Point to abcissa) - giving immediate positive or negative consequences; giving rationales for why the parent would or would not want the youth to perform some behavior; establishing future positive or negative consequences, and requesting acknowledgment from the child. Also measured were "counseling responses". We defined "counseling responses" as any statement which expressed sympathy or encouragement but that did not include specific rationales or contingencies for the behavior in question. We did not teach counseling techniques but did want to measure this type of response since the parents indicated in their initial interviews this was a frequent but ineffective method of dealing with their children's misbehaviors. Also, this would have been an inappropriate response in and of itself to deal with any of the children's behaviors in our vignettes, at least according to the methods we were teaching in the parent-training workshop.

Along the ordinate, we have the percent of vignettes in which the parents included one of these behaviors at least once in their response to any one vignette. In each of the graphs shown, the experimental parents' scores will be indicated by black bars and the control parents' scores will be indicated by the open bars. The parents' responses before treatment are indicated below this midline (pointing) and their responses after treatment are indicated on the top half of the graph. As can be seen, there is little difference between the experimental and control parents' pre-treatment scores (pointing to the bars below the midline). After treatment (lasting approximately 10 weeks for both experimentals and controls) there are considerable differences between the experimental and control parents' scores (pointing to top half of graph). The experimental parents' responses more frequently included statements about issuing immediate and future positive or negative consequences, rationales explaining why the child should or should not perform some behaviors and requests for the child to verbally acknowledge he had heard or understood what was being said to him. As you can see, in these four response categories the experimental parents' responses included more of these kinds of statements in comparison not only to their own pre-training scores but also to the post-treatment scores of the control parents. The number of "counseling statements" remained relatively constant pre- and post-training for the experimental parents but showed an increase in the control parents' post-treatment scores. This was in fact the only response category in which the control parents' post-treatment responses varied to a noticeable extent from their pre-treatment scores.

Thus, in answer to the question of whether or not training was effective, it appeared the experimental parents did learn different ways of responding to children's behavior.

Although it was encouraging that the experimental parents could demonstrate their learning of these new responses by writing them in response to specific situations, a more important question was whether or not training would have an impact on the parents' behavior when actually interacting with their own children.

To help answer this question we asked each parent and child in the experimental and control groups to spend one-half hour engaged in structured activities in a playroom before and after the training program. Most readily observable in this setting were interactions in which the parents gave instructions to their children, the children's response to the instruction, and the ensuing parental response to the children's behavior.

The parents were given a list of brief instructions to give to their child while in the playroom such as "Instruct your child to play quietly by himself/herself and not to interrupt you so that you may fill out the "Problem Behavior Checklist", or "Ask your son to come to the blackboard to work on some arithmetic problems with you." This measure was used because it afforded us an opportunity to look at three important dimensions: 1) how instructions were given by the parent, 2) the youth's compliance or noncompliance, and 3) how parents responded to compliance or noncompliance.

These three areas were a major focus in the parent training program which taught how to give instructions and specific feedback for complying

or not complying with instructions. Likewise in the experimental youth group the children were given many opportunities to learn to comply with instructions from the youth group leaders.

SHOW FIGURE 2

The top graph shows the percent of the various responses the parents gave following their children's compliance with an instruction. The lower graph shows the parents' responses to non-compliance. Each graph shows the experimental and control groups average percentage response before and after treatment. The responses included praise statements, reprimands criticizing some aspects of the child's behavior, a repeat of the original instruction, interacting with the child on the task but without saying anything, giving an instruction different from the original one before the child has completed the original instruction, and giving no verbal response before giving the next instruction.

Before treatment, the predominant parent responses to a child's compliance with an instruction was repeating the instruction, giving a new instruction or giving no verbal response. Rarely did the parents interact with their children while they were complying or offer praise for complying. Approximately 10% of the time they reprimanded or criticized the children for some detail on the way they were complying such as telling them to hurry up with an impatient voice tone. In each of these response categories there was little difference between the experimental and control groups average percentage scores before treatment.

After treatment, the most significant change occurred in the increased percentage of praise statements given by the experimental parents which increased from a pre-treatment score of 7% to a post-treatment score of 37%. The control parents' average increased from 0 to 4% for this response. Less significant were decreases in reprimands, repeating instructions and giving no response. The control parents showed little difference in any area from their pre-treatment scores. There was some tendency for both experimental and control subjects to interact more with their youths but this percentage was low.

Looking at the bottom graph we see again that both groups of parents responded very similarly to their children when they did not comply with their instructions on pre-training assessment. The most frequent response was to repeat the instruction. Giving no response was the second most popular way of handling non-compliance with reprimanding running a close third. About 10% of the time the parents gave new instructions. After treatment, the only significant change for either group was an increase in the percentage of reprimands given by the experimental parents. Reprimands were issued for non-compliance 14% of the time before treatment and 38% of the time after treatment.

Thus, we have evidence that the experimental training program was more effective in changing the parents' responses to compliant and non-compliant responses of their children than traditional treatment programs. Experimental subjects gave significantly more praise after training than controls. Also, there was some tendency that the experimental parents showed a <u>decrease in reprimanding</u>, repeating instructions, and giving no response to compliance. Experimental parents also <u>gave more reprimands</u> to non-compliance.

SHOW FIGURE 3

This next slide shows data from another measure used to determine to what extent the parents would implement skills taught in the training program with their own children. After the parents had given all the instructions to their child in the playroom, they were asked to discuss with their child one problem behavior and try to reach an agreement on how to deal with this behavior in the future. Observers scored whether or not the parent defined a positive consequence the child could earn for performing an alternative behavior and whether or not a negative consequence was defined contingent upon the child's performing the undesired behavior in the future. This graph shows the percent of parents in both the experimental and control groups using these interaction components before and after training.

Looking at the graph, we see there was considerable variance between the control and experimental group scores on these measures prior to training. As you can see, a greater percentage of experimental parents specified the problem behavior and the desired behavior than did the control parents. More control parents specified negative and positive consequences than did the experimental parents.

After treatment, however, there was significantly greater differences between the control and experimental group scores.

In three areas - specifying a positive consequence, specifying the problem behavior in behavioral terms and specifying the desired behavior - the experimental parents' scores ranged from 83 to 100 percent, a dramatic

increase over not only their own pre-treatment scores, but also over the control parents post-treatment scores. A greater percentage of experimental parents specified a negative consequence after treatment than they did before treatment, but there was little remarkable difference from the control parents' post-treatment scores.

Thus, we have seen two sets of data indicating that in a structured setting the experimental parents were using many of the skills taught in the workshop when interacting with their own children.

The next question we asked was what impact, if any, would there be on the children's behavior?

To help answer this question, we directly observed the frequency with which the children complied with instructions given by their parents.

RIGHT SIDE OF FIGURE 2

Compliance was defined as doing what the parent requested immediately without questioning the instruction, mumbling or complaining. The experimental and control youths average percent compliance was comparable prior to treatment. There was an increase of 29 percent for the experimental youths compliance after treatment, compared to only a 2% increase in the control youths post-treatment score. Thus, our experimental parents were obtaining more compliance than the control parents in the structured interactions at the clinic.

Reliability for scoring the vignettes, parent responses to youth compliance and youth compliance was assessed by percent agreement scores

between the independent ratings of two trained observers. The range of their percent agreement for all three measures was 60% to 100% with an overall average of 89%.

We also were interested in how two of our consumers - parents and teachers - felt about the effectiveness of the program. Two indirect measures of the children's behavior were used. We developed a behavior checklist completed by the parents before and after treatment and a school teachers' rating form for the children's classroom behaviors. The parents behavior checklist consisted of 97 questions about the child's behavior. Some examples are:

1. "Does your child get in fights?"
2. "Does your child argue often?"
3. "Is your child usually polite?"
4. "Does your child take longer than 15 seconds to start to follow your instructions?"

The parents responded to each question first by indicating whether or not their child engaged in the behavior described, and secondly by indicating whether or not they considered their child's behavior to be a problem. For example, a parent might respond "yes" to the question, "Does your child get in fights?", but might not necessarily respond "yes" to the second question, "Do you consider this to be a problem?"

Thus, two scores were derived from the checklists - the number of negative behaviors that the parents reported their children engaged in, and the number of these negative behaviors that the parents labeled as "problems".

SHOW FIGURE 4

This figure shows the average pre- and post-treatment checklist scores for the experimental and control parents. The overall average number of negative behaviors reported is indicated by the broken line for the control parents and by the unbroken line for the experimental parents. The overall average number of negative behaviors the parents labeled as problems are represented by the closed bars for the experimental parents and by the open bars for the control parents.

Before treatment, the experimental and control parents reported an average of 23 and 24 negative behaviors respectively and of these the average number of behaviors labeled as problems was 16 for the experimental parents and 14 for the control parents.

After treatment, the experimental parents reported an average of 13 negative behaviors labeling an average of only 3 as "problems". The control parents reported only slightly less negative and problem behaviors than they did before treatment.

SHOW FIGURE 6

School teachers also reported changes in the experimental children's behavior. The teachers rated selected behaviors they described as problems for each experimental and control child on 5 consecutive days before and after treatment. The teachers rated each behavior on a simple 3-point rating scale where "1" was defined as poor or completely unacceptable behavior, "2" was defined as fair or improved but needs more improvement and "3" was defined as good or acceptable behavior (point to the ordinate while defining the scale).

The average ratings for both groups of children before training was between poor and fair. After treatment, the teachers' average ratings for the experimental children increased to 2.6. The control children's ratings increased, though less dramatically, from 1.5 to 1.7. Data collected on a limited number of families who were still available at 5-week and 5-month intervals after treatment indicated that the decrease in parental and teacher reports of youth problems was maintained for the experimental group.

From looking at these 3 sets of data, we have evidence that the experimental parents' use of the skills learned in the training program did have a significant impact on changing their children's behavior. Their children were more compliant as directly observed in the structured interactions, their parents reported their behavior at home as considerably improved as measured by the checklist and the teachers rated their behavior improved in the classroom. On these same measures the control children consistently showed less favorable change or no change.

The evidence, however, is not as conclusive as would be desired - that the parents' use of their new skills was responsible for the changes in the children's behavior. Part of the experimental treatment program was the weekly youth group meetings which may have played a role in changing the children's behavior but we have no data on this component of the program. Looking at all the data, however, we can say with some confidence that the effectiveness of the total experimental program - the parent training program, follow-up individual consultation and youth group - is much greater than the more traditional weekly therapy hours in changing the behaviors of parents as well as their children.

Although the original project investigators left the Ft. Riley Mental Health Center two years ago, the therapists at the base have continued to implement the Whitside Parent Training Program as the primary approach to working with parents and children at the Fort Riley Mental Health Center. They attribute its continued use to the satisfaction they derive from seeing dramatic changes in the behavior of the families they work with.

Current collaborative research efforts between the original investigators and the Ft. Riley therapists are underway to help define more conclusively what aspects of the program are responsible for the effects on the parents' and childrens' behavior.

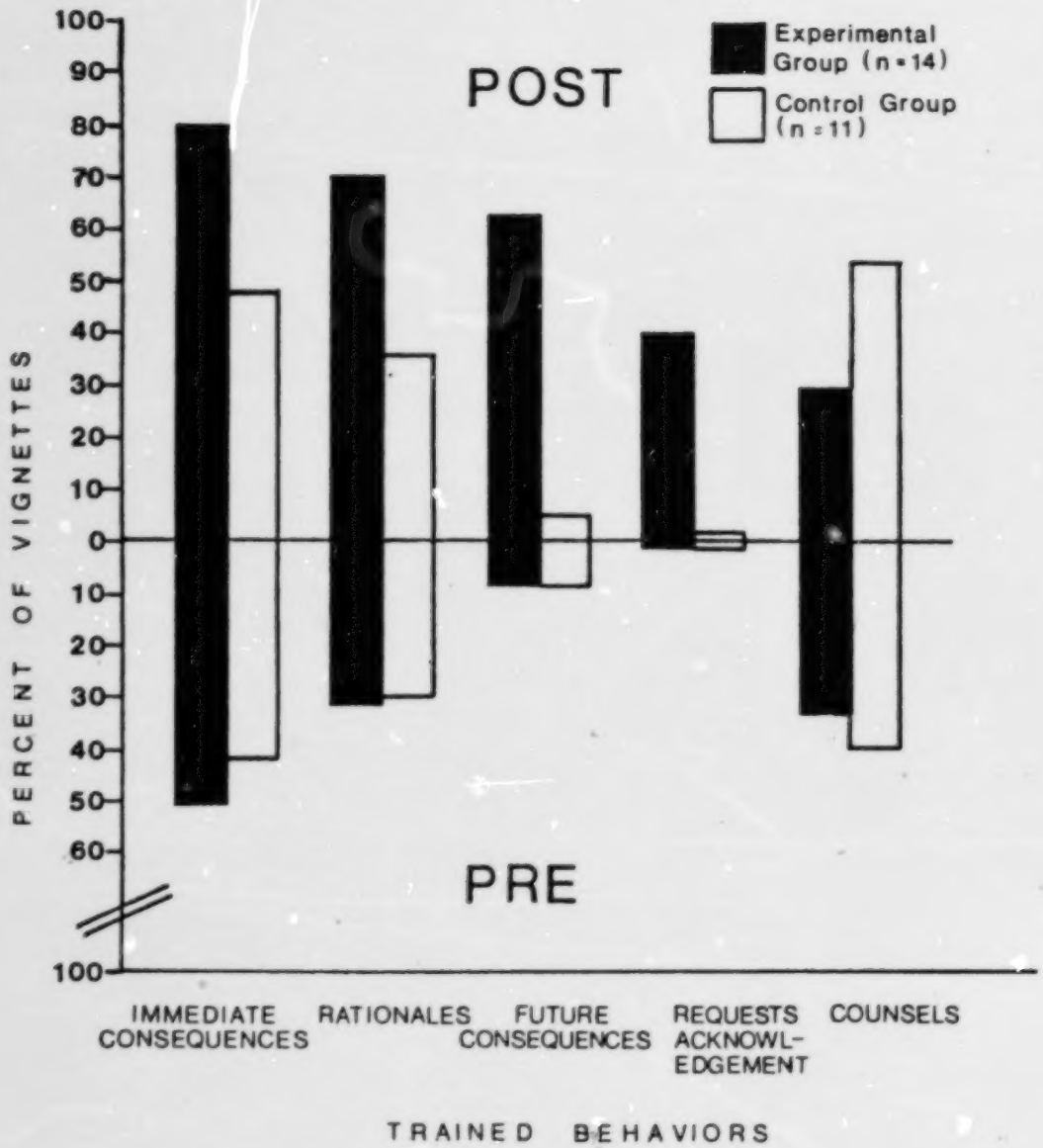

Figure 1: Percent of parent vignette responses that included at least one of the trained behaviors.

Bars above the line indicate the experimental and control groups' post-training scores. Bars below the line indicate the experimental and control groups' pre-training scores.

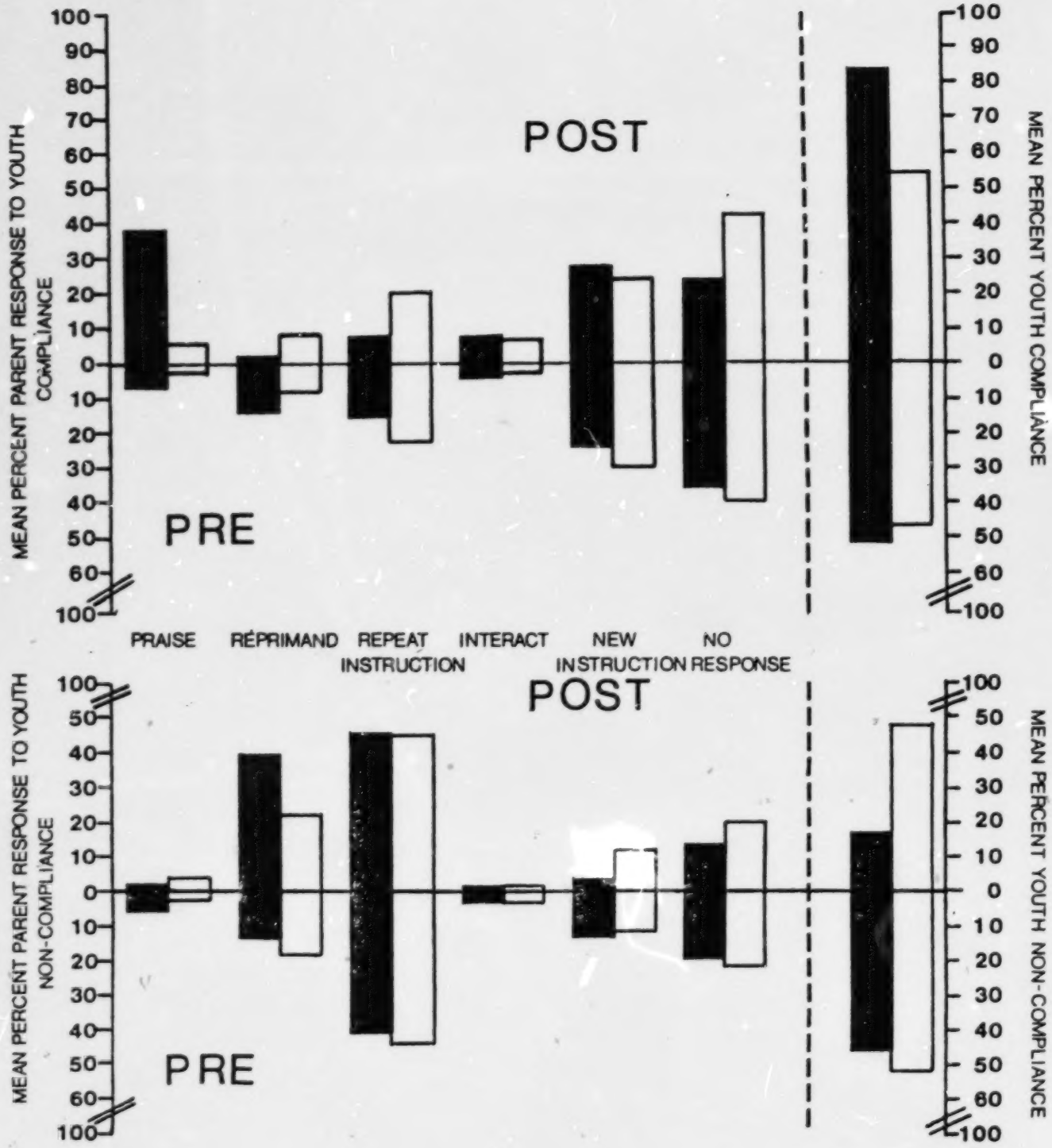

Figure 2: This figure shows the mean percent of experimental (n=14) and control (n=11) parents' responses to youth compliance (top graph) and to youth non-compliance (lower graph) as observed during structured parent-child interactions. The mean percent of experimental (n=14) and control (n=11) youths' compliance with the parents' instructions is shown to the right of the top graph. The mean percent of youth non-compliance is shown to the right of the lower graph.

Bars above the line in all graphs indicate the experimental and control groups' post-training scores. Bars below the line indicate the experimental and control groups' pre-training scores. The closed bars represent the experimental parents and youths and the open bars represent the control parents and youths.

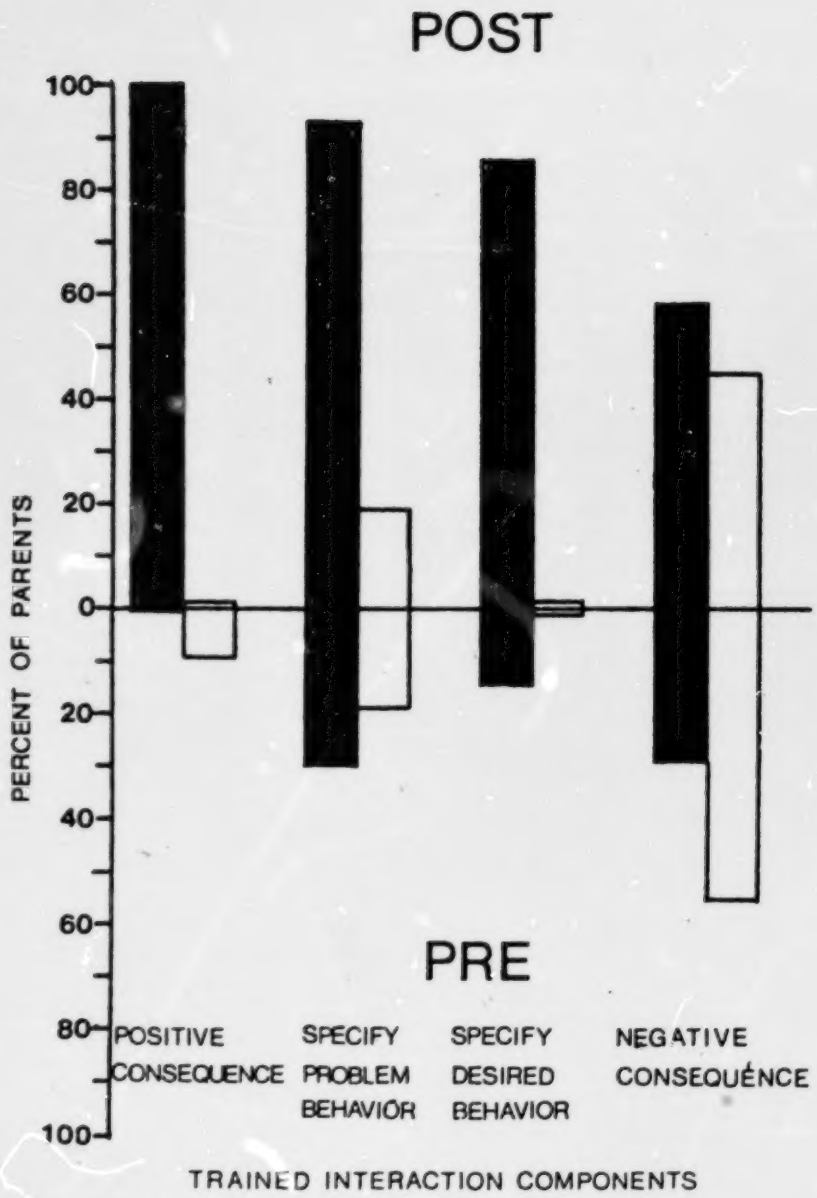

Figure 3: Percent of experimental and control parents using at least one of the interaction components in discussing problem behavior with their youths.

Bars above the line indicate the experimental and control groups' post-training scores. Bars below the line indicate the experimental and control groups' pre-training scores. The closed bars represent the experimental parents and the open bars represent the control parents.

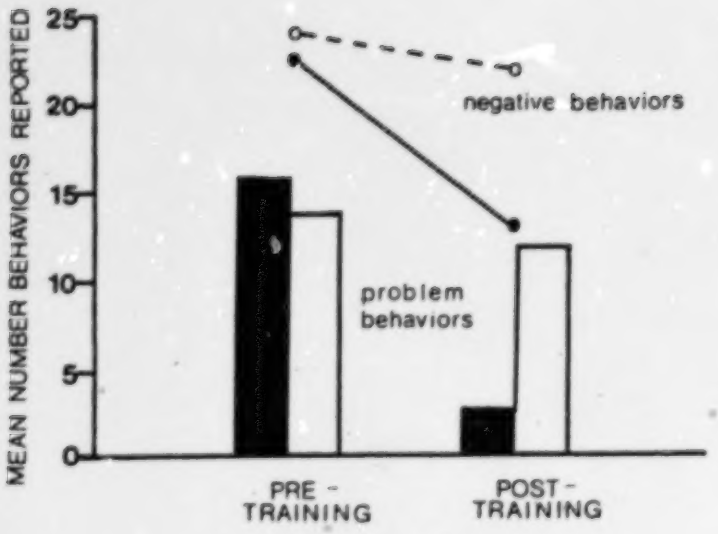

Figure 4: This figure shows the mean number of negative behaviors and problem behaviors occurring at home as rated by the experimental (n=14) and control (n=11) parents. A negative behavior was scored if the parent had observed the youth engaging in that behavior. Of these, a problem behavior was scored only if the parent regarded the youth's negative behavior as a "problem".

The closed bars and the solid line represent the experimental parents and the open bars and dashed line represent the control parents.

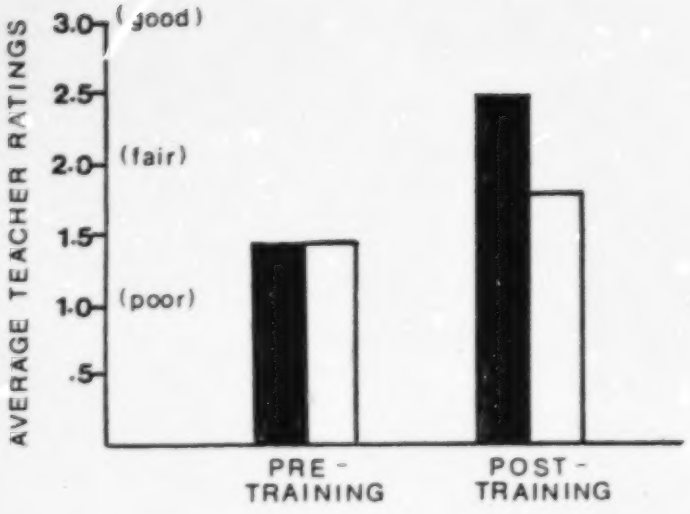

Figure 5: Average teacher ratings of selected school behaviors of experimental (n=11) and control (n=11) youths before and after training. A 3-point rating scale was used with 3 defined as "good", 2 defined as "fair" and 1 defined as "poor".

The closed bars represent the ratings for the experimental youths and the open bars represent the ratings for the control youths.